WE CANNOT ACCEPT THIS INFORMATION OVER THE PHONE. WE MUST HAVE THIS FORM COMPLETED AND RETURNED. THANK YOU.

CARMEL FIRE DEPARTMENT

EMERGENCY MEDICAL SERVICES DIVISION

Patient and Insurance Information Form

PATIENT NAME _____

NAME OF PRIMARY INSURANCE HOLDER (NAME OF PERSON) _____

RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

INFORMATION ON PRIMARY INSURANCE HOLDER:

Social Security Number_____ Date of Birth_____

Address_____

City, State, Zip_____

Phone Number_____

Place of employment _____

Please check your card for the correct claims filing address!

Insurance Company Name_____
(Other than Medicare/Medicaid)

Insurance Company Address_____

City, State, Zip_____ Telephone #_____

ID or Account #_____ Group #_____

Medicare #_____ Medicaid #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by the Carmel Fire Department Ambulance Service. I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services, now or in the future. I further authorize my treatment and transportation by the Carmel Fire Department Ambulance Service and assign Carmel Fire Department Ambulance the right to appeal all claim determinations or denials on my behalf. I understand that I am financially responsible for the services rendered and agree to immediately remit all payments I receive from my insurance company to the Carmel Fire Department. A copy of this authorization is as valid as the original.

In consideration of services rendered or to be rendered by the Carmel Fire Department Ambulance Service, I agree to pay all accumulated charges not covered by insurance. In the event that I do not pay non-covered charges within thirty (30) days of receiving a bill, I agree to pay costs of collection, including reasonable attorney fees and court costs.

Signature_____

Name if other than patient_____

Relationship to patient_____

☐ Unable to sign because_____ ☐ Refused to sign